UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MICHIGAN

KAREN BRIGGS, individually and as personal representative of the ESTATE OF CHRISTOPHER A. NEUMANN,

Plaintiff,

v.

NATIONAL FIRE UNION INSURANCE COMPANY OF PITTSBURGH, PA., AMERICAN INTERNATIONAL GROUP, INC., INTERPUBLIC GROUP OF COMPANIES, INC. WELFARE BENEFIT PLAN, and INTERPUBLIC GROUP OF COMPANIES, INC.

Case No. _____

HON. _____
United States District Judge

COMPLAINT

Now comes Plaintiff Karen Briggs, by and through counsel, and for her Complaint against Defendants, alleges as follows:

Nature of Action

1. This is a claim arising under the Employee Retirement Income Security Act of 1974 ("ERISA") to recover accidental death and dismemberment benefits ("AD&D benefits") against the defendants after defendants unlawfully refused to pay AD&D benefits in the sum of no less than one million dollars ($1,000,000.00) and an additional six hundred thousand dollars ($600,000.00) in dependent benefits despite ample evidence in support of the claim.

Parties

2. Plaintiff Karen Briggs (hereinafter "Ms. Briggs") is a beneficiary of the AD&D benefits at issue in this case and the personal representative of the Estate of Christopher A. Neumann. Ms. Briggs is a resident of Antrim County, Michigan.
3. Defendant National Fire Union Insurance Company of Pittsburgh, PA (hereinafter "National Fire Union") is an insurance company existing under the laws of the Commonwealth of Pennsylvania, having a place of business at 175 Water Street, 18th Floor, New York, New York, and National Fire Union regularly does business within the State of Michigan.

4. Defendant American International Group, Inc., (hereinafter "AIG") is an insurance holding company under the laws of the State of Delaware and is located at 175 Water Street, 18th Floor, New York, New York. AIG controls the activities of National Fire Union and is considered by insurance regulators as the ultimate parent and ultimate responsible party for the activities of National Fire Union. AIG regularly does business within the State of Michigan.

5. Defendant Interpublic Group Of Companies, Inc. Welfare Benefit Plan (hereinafter "Interpublic Plan") is a welfare benefit plan administered "solely in the interest of the participants and beneficiaries" of the plan pursuant to ERISA, 29 U.S.C. § 1104(a)(1), and the Interpublic Plan is an entity that may sue or be sued under ERISA, 29 U.S.C. § 1132(d)(1). The administrative office of the Interpublic Plan is located at 909 Third Avenue, New York, New York, and the Interpublic Plan provides benefits for the employees of the Interpublic Group of Companies, Inc., including employees residing within the State of Michigan.

6. Defendant Interpublic Group of Companies, Inc. (hereinafter "Interpublic"), is a corporation existing under the laws of the State of Delaware having a headquarters at 909 Third Avenue, New York, New York. Interpublic is the ERISA statutory plan sponsor and plan administrator of the Interpublic Plan. Interpublic regularly does business within the State of Michigan.

Jurisdiction and Venue

7. This Court has jurisdiction over this action pursuant to 29 U.S.C. § 1132(e)(1) and 28 § U.S.C. § 1331.
8. The ERISA statute, at 29 U.S.C. § 1133, as well as Department of Labor regulations, at 29 C.F.R. § 2560.503-1, provide a mechanism for administrative or internal appeal of benefits denials. In this case, those avenues of appeal have been exhausted and this matter is now properly before this Court as all pre-suit remedies have been exhausted.
9. Venue is proper in this district pursuant to 29 U.S.C. § 1132(e)(2) and 28 U.S.C. § 1391(b).

Facts Common to All Counts

Enrollment in the Plan

10. At all material times, Christopher A. Neumann (hereinafter "Mr. Neumann") was employed by a division of Interpublic.

11. At all material times, Mr. Neumann was a "participant" in the Interpublic Plan within the meaning of ERISA, 29 U.S.C. § 1002(7).

12. The terms of the Interpublic Plan are set-forth in "Your Benefits Guide 2011" (hereinafter "Benefits Guide") issued to Interpublic employees.

13. At all material times, Ms. Briggs was a designated beneficiary of Mr. Neumann for benefits available under the Interpublic Plan.

14. At all material times, Mr. Neumann was insured under a Group Accident Insurance Policy (hereinafter "National Fire Union Policy") issued to Interpublic by National Fire Union.

15. The National Fire Union policy was delivered to the Interpublic Plan and Interpublic in the State of New York, and upon information and belief, the National Fire Union policy is a funding mechanism for the Interpublic Plan.

16. At all material times, Ms. Briggs was a designated beneficiary of Mr. Neumann for benefits available under the National Fire Union policy.

17. Effective October 6, 2011, Mr. Neumann selected and paid for optional AD&D benefits under the Interpublic Plan by agreeing to pay enhanced premiums so he would have not less than one million dollars ($1,000,000.00) for his beneficiaries if he died accidently, and an additional six hundred thousand dollars ($600,000.00) payable to his dependent, Todd Glenn Lloyd (hereinafter "Mr. Lloyd").

18. Each of Mr. Neumann's pay checks referenced a premium deduction for AD&D coverage under the Interpublic Plan.

Loss & Claim

19. On January 6, 2014, Mr. Neumann and Mr. Lloyd died accidentally and at the same in an aircraft crash near Boyne City, Michigan.

20. Ms. Briggs, the mother of Mr. Neumann, is the duly appointed personal representative for the Estate of Christopher A. Neumann, and she has authority under an order by the Probate Court of Oakland County Michigan to act on his behalf.

21. Mr. Neumann designated Mr. Lloyd as the primary beneficiary, and Ms. Briggs as the secondary beneficiary, for benefits available under the Interpublic Plan.

22. Because Mr. Lloyd died at the same time as Mr. Neumann, Ms. Briggs is the sole beneficiary of Mr. Neumann's benefits under the Interpublic Plan.

23. Ms. Briggs timely submitted a claim for AD&D benefits to the Interpublic Plan, Interpublic, National Fire Union, and AIG.

24. The terms of AD&D benefit coverage provided under the Interpublic Plan are stated in the Benefits Guide:

> Accidental Death and Dismemberment Insurance can provide benefits if you or a covered family member suffers a specific accidental injury or dies as a result of an accident. You can choose from nine coverage amounts and between two coverage categories: Employee only (for you) and Family (for you and your eligible dependents).
>
> How the Accidental Death and Dismemberment Insurance Plan Works
>
> If you choose coverage under the Accidental Death and Dismemberment Insurance Plan and you or a family member suffers an injury or dies as a result of an accident, the Plan will pay the following benefits:
>
> ACCIDENTAL INJURIES COVERED UNDER ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE
>
> THE PLAN PAYS BENEFITS IN THESE AMOUNTS FOR: Loss of Life – 100% of coverage

25. The previous paragraph states the complete terms for AD&D benefit coverage under the Interpublic Plan.

26. The Interpublic Plan does not disclose a single exclusion applicable to AD&D benefit coverage.

27. Neither National Fire Union nor AIG has been granted authority to make discretionary benefit decisions under the terms of the Interpublic Plan.

28. As the sole beneficiary of Mr. Neumann, Ms. Briggs is entitled to benefits under the terms of the Interpublic Plan.

29. As the sole beneficiary of Mr. Neumann, Ms. Briggs is entitled to benefits under the terms of the National Fire Union policy.

30. The National Fire Union policy contains numerous conditions and exclusions that are not disclosed under the terms of the Interpublic Plan instrument.

31. Consequently, liability for benefits under the Interpublic Plan appears to be broader than liability for benefits under the National Fire Union policy.

32. AIG Claims Services of Shawnee, Kansas denied AD&D benefits payable under the National Fire Union policy to Ms. Briggs, and AIG notified Ms. Briggs that she had a right to appeal.

Requests for ERISA Plan Instruments

33. Before appealing the claim denial, Ms. Briggs through counsel wrote to Interpublic and National Fire Union and AIG, requesting a copy of the ERISA plan instruments, the ERISA Summary Plan Description ("SPD"), policies insuring the Plan, the claim file and claim guidelines.

34. AIG produced certain documents but not all requested documents.

35. In response to the request for plan instruments, Ms. Briggs' counsel received from AIG the Benefits Guide that is attached as Exhibit 1.

36. On August 15, 2014, AIG wrote to Ms. Briggs' counsel:

> Enclosed is a copy of the administrative record on encrypted CD format, the password for which was recently e-mailed to you. The administrative record consists of a complete copy of the claim file, the policy, the Summary Plan Description, and all documents given consideration in the claim decision. The AIG claim handling guidelines are not included as they are proprietary.
>
> Interpublic Group of Companies, Inc. also received your letter and have advised they have no other Plan Documents beyond the Summary Plan Description which is contained in the CD.

37. The only plan instrument provided by AIG was the Benefits Guide, and AIG's reference to the "Summary Plan Description" is understood to be a reference to the Benefits Guide.

38. Ms. Briggs' counsel then wrote to National Fire Union and AIG, requesting clarification regarding the available plan documents, and AIG responded on October 30, 2014:

> In response to your recent letters requesting documents which demonstrate that the above captioned policy is governed by ERISA, I must refer you to my letter of August 15, 2014, in which you were supplied with the Summary Plan Description. As also stated in that letter, Interpublic Group of Companies, Inc. advised there are no other Plan Documents beyond the Summary Plan Description. As such, there has been no violation subject to a discretionary penalty for non-compliance.
>
> The policy does not state that it is ERISA-governed and it is not required to do so in order to be subject to ERISA. The coverage is offered as a part of our policyholder's welfare benefits plan and it is not exempt from ERISA.

Exhaustion of Administrative Remedies

39. Ms. Briggs timely appealed the AD&D benefits denial to AIG.

40. On February 23, 2016 AIG issued its final denial.

41. On April 20, 2016 Briggs again requested the ERISA plan instruments from Interpublic in its capacity as plan administrator of the Interpublic Plan.

42. Interpublic did not produce ERISA plan instruments other than referring to the Benefits Guide which had been previously produced.

43. On April 20, 2016, Ms. Briggs appealed to the Interpublic Plan and Interpublic to pay the AD&D benefits claim.

44. Both the Interpublic Plan and Interpublic failed to respond.

45. Ms. Briggs has exhausted all required appeals under the Plan prior to filing this action to seek appropriate relief under ERISA.

Count I:
Claim For Benefits Due Under The National Fire Union Policy
Pursuant To 29 U.S.C. § 1132(a)(1)(B)

46. Plaintiff restates all of the previous allegations as incorporated herein.

47. ERISA authorizes beneficiaries such as Ms. Briggs to enforce their rights to benefits pursuant to 29 U.S.C. § 1132(a)(1)(B).

48. Ms. Briggs is entitled to recover AD&D benefits under the coverage provided by the National Fire Union policy.

49. Ms. Briggs made a proper claim for benefits, and Ms. Briggs has exhausted all administrative remedies, but the claim was wrongfully denied.

50. AIG made the administrative decisions regarding Ms. Briggs' claim under the National Fire Union policy, and AIG is liable along with its subsidiary, National Fire Union, for benefits owed to Ms. Briggs.

51. To the extent that AIG or National Fire Union assert any alleged exclusions to coverage under the National Fire Union policy, AIG has the burden of proving that such exclusions apply to the circumstances of this case.

52. Under the circumstances present in this case, AIG and National Fire Union are estopped from asserting any exclusions to coverage insofar as:

a. AIG and National Fire Union represented that beneficiaries of employees of Interpublic were covered for losses due to accidental death under the National Fire Union policy;

b. AIG and National Fire Union intended that employees of Interpublic would purchase coverage based on these representations;

c. The National Fire Union policy actually contained exclusions that severely limited or defeated coverage for some types of accidents most likely to result in death;

d. AIG and National Fire Union knew of the policy exclusions designed to defeat coverage in such accidental death circumstances;

e. AIG and National Fire Union did not disclose these policy exclusions to Mr. Neumann when he was purchasing coverage;

f. Mr. Neumann was unaware of the policy exclusions that severely limited or defeated coverage for some types of accidents most likely to result in death; and

g. Mr. Neumann reasonably and detrimentally relied on the representations that the coverage would provide benefits for his beneficiaries in the event of his death in an accident such as the one at issue in this case.

53. Therefore, it would be appropriate for the Court to conduct a *de novo* review of this benefit action pursuant *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), and to enforce Ms. Briggs' entitlement to benefits under the coverage provided by the National Fire Union policy pursuant to 29 U.S.C. § 1132(a)(1)(B) together with interest at an equitable rate.

54. It would also be appropriate for the Court to award Ms. Briggs her costs and reasonable attorney fees incurred in this action pursuant to 29 U.S.C. § 1132(g)(1).

Wherefore, Ms. Briggs requests this Honorable Court to enforce Ms. Briggs' entitlement to benefits under the coverage provided by the National Fire Union policy pursuant to 29 U.S.C. § 1132(a)(1)(B) together with interest at an equitable rate, and to award Ms. Briggs her costs and reasonable attorney fees incurred in this action pursuant to 29 U.S.C. § 1132(g)(1).

Count II
Claim For Benefits Due Under The Interpublic Plan
Pursuant To 29 U.S.C. § 1132(a)(1)(B)

55. Plaintiff restates all of the previous allegations as incorporated herein.

56. ERISA authorizes beneficiaries such as Ms. Briggs to enforce their rights to benefits pursuant to 29 U.S.C. § 1132(a)(1)(B).

57. Ms. Briggs is entitled to recover AD&D benefits under the coverage provided by the Interpublic Plan.

58. Interpublic was responsible for making the administrative decisions under the Interpublic Plan, and Interpublic is liable along with the Interpublic Plan for benefits owed to Ms. Briggs.

59. The complete terms of the Interpublic Plan are stated in the Benefits Guide furnished by Interpublic, which does not identify a single exclusion applicable to its AD&D coverage.

60. Thus, to the extent that an exclusion contained in the National Fire Union policy is deemed to be enforceable with respect to its coverage, the coverage provided by the Interpublic Plan is substantially broader than that of the National Fire Union policy.

61. Interpublic made the administrative decisions regarding Ms. Briggs' claim under the Interpublic Plan, and Interpublic is liable for benefits owed to Ms. Briggs.

62. To the extent that Interpublic asserts any alleged exclusions to coverage under the Interpublic Plan, Interpublic has the burden of proving that such exclusions apply to the circumstances of this case.

63. Under the circumstances present in this case, Interpublic is estopped from asserting any exclusions to coverage insofar as:

a. Interpublic represented that beneficiaries of employees of Interpublic were covered for losses due to accidental death under the Interpublic Plan;

b. Interpublic intended that employees of Interpublic would purchase coverage based on these representations;

c. The Interpublic Plan, itself or through the funding mechanism of the National Fire Union policy, actually contained exclusions that severely limited or defeated coverage for some types of accidents most likely to result in death;

d. Interpublic knew of the exclusions designed to defeat coverage in such accidental death circumstances;

e. Interpublic did not disclose these policy exclusions to Mr. Neumann when he was purchasing coverage;

f. Mr. Neumann was unaware of the policy exclusions that severely limited or defeated coverage for some types of accidents most likely to result in death; and

g. Mr. Neumann reasonably and detrimentally relied on the representations that the coverage would provide benefits for his beneficiaries in the event of his death in an accident such as the one at issue in this case.

64. Therefore, it would be appropriate for the Court to conduct a de novo review of this benefit action pursuant *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), and to enforce Ms. Briggs' entitlement to benefits under the coverage provided by the Interpublic Plan pursuant to 29 U.S.C. § 1132(a)(1)(B) together with interest at an equitable rate.

65. It would also be appropriate for the Court to award Ms. Briggs her costs and reasonable attorney fees incurred in this action pursuant to 29 U.S.C. § 1132(g)(1).

Wherefore, Ms. Briggs requests this Honorable Court to enforce Ms. Briggs' entitlement to benefits under the coverage provided by the Interpublic Plan pursuant to 29 U.S.C. § 1132(a)(1)(B) together with interest at an equitable rate, and to award Ms. Briggs her costs and reasonable attorney fees incurred in this action pursuant to 29 U.S.C. § 1132(g)(1).

Count III
Claim For Equitable Relief Against National Fire Union And AIG Pursuant To 29 U.S.C. § 1132(a)(3)

66. Plaintiff restates all of the previous allegations as incorporated herein.

67. In the alternative, National Fire Union and AIG are liable to Ms. Briggs for appropriate equitable relief pursuant to 29 U.S.C. § 1132(a)(3).

68. National Fire Union and AIG are fiduciaries within the meaning of 29 U.S.C. §1002(21)(A) because they exercised authority or control over management and disposition of assets of the Interpublic Plan, including proceeds of the National Fire Union policy.

69. One of the many fiduciary duties owed to ERISA plan participants and beneficiaries is a duty to "convey complete and correct material information to a beneficiary," including a "duty to communicate to the beneficiary material facts affecting the interest of the beneficiary which he knows the beneficiary does not know and which the beneficiary needs to know...." *Krohn v. Huron Mem. Hosp.*, 173 F.3d 542, 548 (6th Cir. 1999).

70. A fiduciary breaches its duties by materially misleading plan participants, regardless of whether the fiduciary's statements or omissions were made negligently or intentionally. *Varity Corp. v. Howe*, 516 U.S. 489, 512 (1996).

71. National Fire Union and AIG designed the sale of National Fire Union AD&D policies to take advantage of ERISA features by selling the policies to private sector employers for the benefit of their employees.

72. National Fire Union and AIG had a fiduciary duty to disclose to plan participants all terms and conditions of National Fire Union policy coverage, including but not limited to exclusions that could severely limit or defeat coverage for some types of accidents most likely to result in death, which was the essential purpose of the coverage.

73. National Fire Union and AIG breached their fiduciary duties by failing to disclose these terms and conditions of the National Fire Union policy to Interpublic Plan participants such as Mr. Neumann.

74. An internal National Fire Union and AIG document has disclosed that the loss ratio for their AD&D benefits was merely 19%.

75. A loss ratio of 19% is indicative of illusory insurance coverage.

76. Consequently, the failure to disclose essential terms and conditions of National Fire Union policy coverage to ERISA plan participants, among other things, has permitted National Fire Union and AIG to realize excessive profits.

77. If benefits are not awarded to Ms. Briggs pursuant to 29 U.S.C. § 1132(a)(1)(B), then Ms. Briggs is entitled to appropriate equitable relief against National Fire Union and AIG pursuant to 29 U.S.C. § 1132(a)(3) as a result of their improper actions.

78. Such equitable relief may include monetary compensation in the form of "surcharge" for losses resulting from the improper actions of National Fire Union and AIG. See *Cigna Corp. v. Amara*, 563 U.S. 421, 442 (2011) ("The surcharge remedy extended to a breach of trust committed by a fiduciary encompassing any violation of a duty imposed upon that fiduciary.").

79. Therefore, it would be appropriate for the Court to enforce Ms. Briggs' entitlement to appropriate equitable relief against National Fire Union and AIG, including but not limited to monetary relief in the form of surcharge, pursuant to 29 U.S.C. §1132(a)(3), together with interest at an equitable rate.

80. It would also be appropriate for the Court to award Ms. Briggs her costs and reasonable attorney fees incurred in this action pursuant to 29 U.S.C. § 1132(g)(1).

Wherefore, Ms. Briggs requests this Honorable Court to enforce Ms. Briggs' entitlement to appropriate equitable relief against National Fire Union and AIG, including but not limited to monetary relief in the form of surcharge, pursuant to 29 U.S.C. §1132(a)(3), together with interest at an equitable rate, and to award Ms. Briggs her costs and reasonable attorney fees incurred in this action pursuant to 29 U.S.C. § 1132(g)(1).

Count IV
Claim For Equitable Relief Against Interpublic
Pursuant To 29 U.S.C. § 1132(a)(3)

81. Plaintiff restates all of the previous allegations as incorporated herein.

82. In the alternative, Interpublic is liable to Ms. Briggs for appropriate equitable relief pursuant to 29 U.S.C. § 1132(a)(3).

83. Interpublic is a fiduciary within the meaning of 29 U.S.C. §1002(21)(A) because it exercised authority or control over management and disposition of assets of the Interpublic Plan.

84. Among other duties, Interpublic had a duty to "convey complete and correct material information to a beneficiary," including a "duty to communicate to the beneficiary material facts affecting the interest of the beneficiary which he knows the beneficiary does not know and which the beneficiary needs to know...." *Krohn v. Huron Mem. Hosp.*, 173 F.3d 542, 548 (6th Cir. 1999).

85. A fiduciary breaches its duties by materially misleading plan participants, regardless of whether the fiduciary's statements or omissions were made negligently or intentionally. *Varity Corp. v. Howe*, 516 U.S. 489, 512 (1996).

86. Interpublic had a fiduciary duty to disclose to plan participants all terms and conditions of Interpublic Plan coverage, including but not limited to exclusions that could severely limit or defeat coverage for some types of accidents most likely to result in death, which was the essential purpose of the coverage.

87. Additionally, in its capacity as plan administrator, ERISA imposes on Interpublic a duty to provide plan participants with a summary plan description (SPD) containing the following information:

> (a) A summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries as provided in section 1024(b) of this title. The summary plan description shall include the information described in subsection of this section, shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan. A summary of any material modification in the terms of the plan and any change in the information required under subsection (b) of this section shall be written in a manner calculated to be understood by the average plan participant and shall be furnished in accordance with section 1024(b)(1) of this title.
>
> (b) The summary plan description shall contain the following information: The name and type of administration of the plan; in the case of a group health plan (as defined in section 1191b(a)(1) of this title), whether a health insurance issuer (as defined in section 1191b(b)(2) of this title) is responsible for the financing or administration (including payment of claims) of the plan and (if so) the name and address of such issuer; the name and address of the person designated as agent for the service of legal process, if such person is not the administrator; the name and address of the administrator; names, titles, and addresses of any trustee or trustees

> (if they are persons different from the administrator); a description of the relevant provisions of any applicable collective bargaining agreement; the plan's requirements respecting eligibility for participation and benefits; a description of the provisions providing for nonforfeitable pension benefits; circumstances which may result in disqualification, ineligibility, or denial or loss of benefits; the source of financing of the plan and the identity of any organization through which benefits are provided; the date of the end of the plan year and whether the records of the plan are kept on a calendar, policy, or fiscal year basis; the procedures to be followed in presenting claims for benefits under the plan including the office at the Department of Labor through which participants and beneficiaries may seek assistance or information regarding their rights under this chapter and the Health Insurance Portability and Accountability Act of 1996 with respect to health benefits that are offered through a group health plan (as defined in section 1191b(a)(1) of this title), the remedies available under the plan for the redress of claims which are denied in whole or in part (including procedures required under section 1133 of this title), and if the employer so elects for purposes of complying with section 1181(f)(3)(B)(i) of this title, the model notice applicable to the State in which the participants and beneficiaries reside.
>
> 29 U.S.C. § 1022.

88. Interpublic had a fiduciary duty to provide an accurate Summary Plan Description to ERISA plan participants such as Mr. Neumann.

89. Interpublic did not furnish Mr. Neumann with an SPD containing this required information.

90. Interpublic never disclosed in an SPD or the Benefits Guide that the Interpublic Plan or its funding mechanism contained any exclusions that severely limited or defeated coverage for some types of accidents most likely to result in death, which was the essential purpose of the coverage.

91. Consequently, Interpublic breached its fiduciary duty by misleading Mr. Neumann as to the extent of his coverage and by failing to disclose essential terms and conditions of Interpublic Plan coverage to Mr. Neumann.

92. Therefore, if benefits are not awarded to Ms. Briggs pursuant to 29 U.S.C. § 1132(a)(1)(B), then Ms. Briggs is entitled to appropriate equitable relief against Interpublic pursuant to 29 U.S.C. § 1132(a)(3) as a result of its improper actions.

93. Such equitable relief may include monetary compensation in the form of "surcharge" for losses resulting from the improper actions of Interpublic. See *Cigna Corp. v. Amara*, 563 U.S. 421, 442 (2011) (“The surcharge remedy extended to a breach of trust committed by a fiduciary encompassing any violation of a duty imposed upon that fiduciary.”).

94. Therefore, it would be appropriate for the Court to enforce Ms. Briggs' entitlement to appropriate equitable relief against Interpublic, including but not limited to monetary relief in the form of surcharge, pursuant to 29 U.S.C. §1132(a)(3), together with interest at an equitable rate.

95. It would also be appropriate for the Court to award Ms. Briggs her costs and reasonable attorney fees incurred in this action pursuant to 29 U.S.C. § 1132(g)(1).

Wherefore, Ms. Briggs requests this Honorable Court to enforce Ms. Briggs' entitlement to appropriate equitable relief against Interpublic, including but not limited to monetary relief in the form of surcharge, pursuant to 29 U.S.C. §1132(a)(3), together with interest at an equitable rate, and to award Ms. Briggs her costs and reasonable attorney fees incurred in this action pursuant to 29 U.S.C. § 1132(g)(1).

Respectfully submitted,

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Dated: October 4, 2016

Exhibit 1

YOUR BENEFITS GUIDE 2011

IPG

Highlights of the Interpublic Benefits Program for U.S. Employees

PLAN	COVERAGE	PAGE
MEDICAL	■ Two Preferred Provider Organization (PPO) choices	2–6
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DENTAL	■ Preferred Dentist Program (PDP®) ■ Dental Maintenance Organization (DMO®), available in most locations	8–10
VISION	■ Coverage includes exams, lenses and frames	11–12
FLEXIBLE SPENDING ACCOUNTS	■ Health Care Spending Account and Dependent Care Spending Account administered by WageWorks to help pay for out-of-pocket expenses on a pre-tax basis	13–15
TRANSPORTATION MANAGEMENT PROGRAM	■ Public Transportation and Parking Accounts administered by WageWorks to help pay for transit expenses on a pre-tax basis	16–17
LONG-TERM CARE INSURANCE	■ Home, community or nursing home long-term care benefits available to you and your family	18
ADOPTION ASSISTANCE PLAN	■ Reimbursement for eligible adoption-related expenses	18
SHORT-TERM DISABILITY/ SALARY CONTINUATION	■ Short-Term Disability provides a benefit equal to 100% or 50% of your pay, depending on your length of service	18
LONG-TERM DISABILITY	■ Basic Long-Term Disability (Company-provided) equal to 50% of pay, up to $5,000 monthly benefit maximum ■ Employee Optional Long-Term Disability, equal to 60% of pay, up to $25,000 (including basic) monthly benefit maximum	19
LIFE INSURANCE	■ Basic Life Insurance (Company-provided) for each employee equal to 1 x pay ■ Employee Optional Life Insurance: Eight coverage options or Waive Coverage ■ Spouse Life Insurance: Ten coverage options or Waive Coverage ■ Child Life Insurance: Two coverage options or Waive Coverage	20–21
ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE	■ Nine coverage options for Employee Only or Family	22–23
IDENTITY THEFT ASSISTANCE	■ ID Theft Assistance	24
BUSINESS TRAVEL ACCIDENT	■ Benefits for injury or death during business travel	25
TRAVEL ASSIST	■ Travel assistance services when over 100 miles away from residence or place of employment	25
GROUP LEGAL	■ Coverage includes a wide range of services for personal legal matters	26
GROUP HOME AND AUTO INSURANCE	■ Home and auto insurance at group rates	27

Welcome to Your Benefits

Interpublic is pleased to offer you a comprehensive array of benefit plans that can help you meet your health care, financial protection and personal savings needs. Under the Benefits Program, you can elect coverage under a variety of benefit plans and from a selection of choices that allows you to customize a package of benefits that is right for you and your family. Each year, you have the opportunity to review your health care and other benefit coverage and make elections that best meet your needs.

The Medical Plan can help protect you and your family from the high cost of medical care and services. You have different coverage choices or you can elect to waive coverage (if you have other medical coverage available to you).

This Benefits Guide provides the information you need to understand the Benefits Program and to make educated decisions during enrollment. However, it is up to you to read through this Benefits Guide, learn about the Benefits Program and each of the plans available, and to consider the choices available to you to ensure you make the best selections possible.

Please note: *You will not be able to elect coverage or make changes to your coverage for 2011 mid-year unless you qualify for a change in work or family status. Otherwise, you will be able to make changes to your coverage for 2012 during the next annual enrollment period, which will take place in the fall of 2011.*

How to Use This Guide

REVIEW…	Learn about each of the benefit plans available	Pages 2–27
COMPARE…	Review key information about the Benefits Program, including terms to know, under “Benefits Basics”	Pages 27–30
LEARN MORE…	Find the right resources to answer your questions about the Benefits Program under “Contact Information”	Page 31

Plan Cost Estimator

The Plan Cost Estimator is an online tool that compares health care plan options and costs based on the personal health information you enter. It’s free, confidential and only takes a few minutes. Use the results to make benefit decisions that provide the care you need at the right cost. Visit **www.interpublicbenefitsonline.ehr.com** to start using the Plan Cost Estimator today **(User ID: ipgemployee, Security Code: password)**.

What Is Inside

This Benefits Guide provides an overview of IPG’s Benefits Program and the benefit plans offered for 2011. It includes key information you need to know about each benefit plan, the choices available and how each benefit plan works.

Medical

Preferred Provider Organization (PPO)

A Preferred Provider Organization (PPO) offers flexibility in how you receive health care services while helping to manage costs. The Company offers two PPOs through the United-Healthcare Choice Plus Network—PPO1 and PPO2.

Finding Network Providers

PPO options—visit the UnitedHealthcare website at **www.myuhc.com** or call them directly at **1-866-679-0946**.

The Interpublic Plan is part of the UnitedHealthcare Choice Plus Network. Please check with UnitedHealthcare to find out if your doctors are in the UnitedHealthcare Choice Plus Network.

When you contact providers, please be sure to identify yourself as an Interpublic employee.

How the Options Work

Each time you or a covered family member needs medical attention, you have a choice on how to receive health care services:

- **In-network,** by visiting providers who participate in the UnitedHealthcare Choice Plus Network. The network includes doctors, hospitals and other health care providers who have agreed to provide care and services at discounted fees (which means you pay less out-of-pocket) to participating members. When you receive care through the UnitedHealthcare Choice Plus Network, you receive higher benefits for eligible expenses. In addition, you can visit any network doctor you choose each time you need health care services; you do not have to choose or get a referral from a Primary Care Physician (PCP).
- **Out-of-network,** by visiting licensed health care providers who do not participate in the UnitedHealthcare Choice Network. While you can still receive benefits for eligible expenses incurred out-of-network, you pay more out-of-pocket for this health care service.

Exclusive Provider Organization (EPO)

An EPO is a medical care arrangement that offers a range of health care services only through a network of participating providers, including doctors, hospitals and other health care facilities. It does not have out-of-network benefits.

When you receive care through the Plan's network, you need to show your Plan ID card (which you will receive after enrollment in the Plan) and typically pay a copay each time you receive care. However, if you visit health care providers outside the Plan's network, your care is not covered—except in emergencies—which means you pay the entire cost for your health care services received out-of-network.

Finding Network Providers

EPO Option—Visit the Aetna website at **www.aetna.com** or call them directly at **1-866-253-8886**.

The Interpublic Plan is part of the Aetna Select Open Access Network. Please check with Aetna to find out if your doctors are in the Aetna Select Open Access Network.

When you contact providers, please be sure to identify yourself as an Interpublic employee.

Each time you need to visit a doctor or other health care provider, you choose between receiving care in-network or out-of-network.

IN-NETWORK	OUT-OF-NETWORK (PPO PLAN ONLY)
You must meet a deductible for most services before the Plan shares in the cost of eligible expenses.	You must meet a higher deductible before the Plan shares in the cost of eligible expenses.
You typically pay a copay for each office visit to a network provider and a lower coinsurance amount for other types of care than if you visited a non-network provider.	Once you meet the deductible, you typically pay a percentage of the cost of all eligible expenses. You pay a higher coinsurance amount for all expenses than if you visited a network provider.
Your share of the coinsurance amount is applied to pre-negotiated discounted fees, so you pay less in out-of-pocket expenses.	Your share of the coinsurance amount is applied to your provider's full fees, up to reasonable and customary limits. You are responsible to pay out-of-pocket any amount above the reasonable and customary limits for your care, in addition to your coinsurance percentage.
The PPO starts paying 100% of your eligible expenses sooner since your in-network annual out-of-pocket maximum is lower.	You have a higher annual out-of-pocket maximum to reach before the PPO pays 100% of your eligible expenses for the remainder of the calendar year.

MEDICAL PLAN COMPARISON

	UNITEDHEALTHCARE CHOICE PLUS NETWORK (PPO1)		UNITEDHEALTHCARE CHOICE PLUS NETWORK (PPO2)		AETNA SELECT OPEN ACCESS (EPO)
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK COVERAGE ONLY
ANNUAL DEDUCTIBLE*	Ind: $500 Family: $1,000	Ind: $1,000 Family: $2,000	Ind: $800 Family: $1,600	Ind: $1,600 Family: $3,200	Ind: $500 Family: $1,000
COINSURANCE (PLAN PAYS)	80% after deductible	60% after deductible	80% after deductible	60% after deductible	90% after deductible
OFFICE VISIT COPAY**	PCP: $25 Specialist: $45	N/A	PCP: $25 Specialist: $45	N/A	PCP: $25 Specialist: $45
HOSPITAL SERVICES (INPATIENT)	$500 copay per confinement; then plan pays 80% coinsurance	$700 copay per confinement; then plan pays 60% coinsurance after deductible	$600 copay per confinement; then plan pays 80% coinsurance	$800 copay per confinement; then plan pays 60% coinsurance after deductible	$500 copay per confinement; then plan pays 90% coinsurance after deductible
NON-NOTIFICATION PENALTY	$250	$250	$250	$250	$250
EMERGENCY ROOM	$250 copay (applies to inpatient copay if admitted)	$250 copay*** (applies to inpatient copay if admitted)	$250 copay (applies to inpatient copay if admitted)	$250 copay*** (applies to inpatient copay if admitted)	$250 copay (applies to inpatient copay if admitted)
PRESCRIPTION DRUGS					
	Retail (up to 30-day supply)		**Retail (up to 30-day supply)**		**Retail (up to 30-day supply)**
Generic:	$7 copay		$7 copay		$7 copay
Formulary Brand:	35% ($65 max)		35% ($65 max)		35% ($65 max)
Non-Formulary Brand:	45% ($100 max)		45% ($100 max)		45% ($100 max)
	Mail Order (up to 90-day supply)		**Mail Order (up to 90-day supply)**		**Mail Order (up to 90-day supply)**
Generic:	$15 copay		$15 copay		$15 copay
Formulary Brand:	35% ($165 max)		35% ($165 max)		35% ($165 max)
Non-Formulary Brand:	45% ($250 max)		45% ($250 max)		45% ($250 max)
ANNUAL OUT-OF- POCKET MAXIMUM*†	Ind: $3,000 Family: $6,000	Ind: $5,000 Family: $10,000	Ind: $3,750 Family: $7,500	Ind: $5,500 Family: $11,000	Ind: $3,000 Family: $6,000
LIFETIME MAXIMUM	None	None	None	None	None

*Copays, amounts above reasonable and customary limits, and the Non-Notification Penalty and all copays and coinsurance amounts for prescription drugs do not apply toward the deductible or the annual out-of-pocket maximum.

**Copays are waived for any in-network preventive care services covered under the Patient Protection and Affordable Care Act.

***$250 copay applies only if a true emergency; otherwise, the applicable plan out-of-network coinsurance will apply. True emergencies will be covered at in-network levels.

†Co-insurance applies toward the out-of-pocket maximum.

Mental Health and Substance Abuse Care: Under PPO1, PPO2 and Aetna Select EPO Plan

The PPO choices and the EPO cover eligible inpatient and outpatient mental health and substance abuse care for:

- Stress management
- Depression
- Eating disorders
- Coping with grief and loss
- Alcohol or drug dependency
- Anger management
- Mental disorders

All mental health and substance abuse expenses are subject to the same copays and coinsurance as any other condition.

If you are enrolled in the PPO plans, each time you or a family member needs care, call UnitedHealthcare at **1-866-679-0946** and follow the prompt. You will then speak to a United Behavioral Health (UBH) counselor, who is an experienced mental health clinician. The UBH counselor will help you identify a provider that may best meet your needs and answer questions about your benefits.

If you are enrolled in the Aetna EPO, please call **1-866-253-8886**.

NurseLine

If you're unsure whether a condition requires care or need help finding a provider, you can use your plan's NurseLine as a resource. The NurseLine offers support for taking self-care measures, communicating with your doctor and making difficult decisions. To find health information and education 24 hours a day, call the NurseLine at **1-800-846-4678**. (For the hearing impaired, please call the National Relay Center.) For more information, visit **www.myuhc.com** or for Aetna, call **1-800-556-1555.**

EMPLOYEE ASSISTANCE PROGRAM (EAP)—AVAILABLE TO ALL EMPLOYEES REGARDLESS OF HEALTH CARE PLAN

The Corporate Family Network (CFN) is an Employee Assistance Program (EAP) that provides confidential counseling, financial and legal services, as well as family education and dependent care referral assistance. These services are in place to assist you through difficult personal conflicts, financial concerns and legal situations. They can also help guide you through family situations, such as finding child care and elder care or adoption planning. CFN provides up to eight free counseling sessions per issue and/or assessment and referral for long-term counseling.

To learn more about CFN's services, log on to **www.moretolifeonline.com**. You can also call CFN's 24-hour toll-free number at **1-888-777-0052** (1-877-267-1428 for the hearing-impaired) to set up appointments or to receive a crisis telephone consultation.

$100 Gift Card for Participating in Certain Health Management Programs

The IPG health plans offer voluntary health management programs for employees:

- The disease management program offers assistance with diagnostic and therapeutic care for chronic conditions, such as asthma, diabetes or heart disease.
- The healthy pregnancy program provides education and support during a pregnancy, so that the mother and baby can be as healthy as possible. **You must enroll during your first trimester to be eligible.**

To increase participation of eligible plan members and maximize the benefits of these programs, you will receive a $100 gift card for completing the applicable health management program.

Based on claims history, if you or a dependent is eligible, you will be contacted by UHC or Aetna directly. If you or a covered dependent becomes pregnant and wants to participate in the health pregnancy program, call UHC at 1-800-411-7984 or Aetna at 1-800-272-3531.

COVERAGE FOR INFERTILITY TREATMENT

You can receive coverage for infertility treatment under the Medical Plan and the Prescription Drug Plan. Under the UnitedHealthcare Choice Plus Network Medical Plan options, you can receive coverage for eligible expenses, up to a:
– $2,000 annual maximum; and
– $4,000 lifetime maximum.
Covered medical expenses include artificial insemination and Assisted Reproductive Technologies (ART), including in vitro fertilization (IVF) and similar procedures known as GIFT and ZIFT.

Please note: *If you choose coverage under the Aetna EPO Plan, please contact Aetna for details on infertility treatment and available coverage.*

Prescription Drug for PPO1, PPO2 and Aetna EPO

If you choose medical coverage, you will have access to prescription drug coverage through the Prescription Drug Plan administered by Express Scripts. Under the Plan, there are two ways to purchase your prescription drugs:

- **Retail Program.** If you have an immediate or a short-term prescription drug need, you can fill your prescription at one of the participating retail pharmacies to receive up to a 30-day supply of medication.

  Show your prescription drug ID card (which you will receive after you enroll) to your network pharmacist to receive benefits under the Plan.

  If you purchase your prescription drugs at a non-participating pharmacy, you will need to pay the full cost of the prescription drugs up-front and then submit a paper claim to Express Scripts for reimbursement of eligible expenses.

- **Required Mail Order/Home Delivery Program.** Starting in 2011, if you have a medical condition that requires you to fill a prescription more than three times or if you are taking a maintenance medication, you must use the mail order program. It's easy to enroll in mail order and it's less expensive for both you and the company. Under the Program you can receive up to a 90-day supply of each prescription drug. If you fill your prescription at a retail pharmacy more than three times, you will pay the full cost.

	Retail Program (Per prescription; 30-day supply)	**Mail Order Program** (Per prescription; 90-day supply)
Generic	$7 copay	$15 copay
Formulary	35% ($65 max)	35% ($165 max)
Non-Formulary	45% ($100 max)	45% ($250 max)

Your prescription drugs typically will arrive within 14 calendar days after the Plan receives your order. If you need refills, you can order them online, by phone or by mail.

For more information about the Prescription Drug Plan, including the formulary list, please contact:

- Express Scripts at 1-888-418-2589 or **www.express-scripts.com**. Express Scripts updates its formulary on a quarterly basis, and it's possible that specific drugs may change coverage tiers when these updates occur.

PRESCRIPTION DRUG LIMITATIONS

The following are available through the Retail or Mail Order Program with limitations:

- Erectile Dysfunction Drugs (Viagra®, Levitra®, etc.)
- Smoking Deterrents
- Fertility Drugs ($2,000 annual limit, $4,000 lifetime limit separate from the medical plan allowance)
- Retin-A (covered through age 29) and Avita

For information about limitations, please contact UnitedHealthcare or Aetna directly.

The Prescription Drug Plan does not cover over-the-counter (OTC) medications (medications that do not require a prescription).

Other limitations may apply.

Please note: *There are no deductibles to meet before you receive benefits. Your out-of-pocket prescription drug expenses do not count toward PPO1, PPO2 or EPO Plan deductibles or out-of-pocket maximums.*

Dental

The Dental Plan can help you pay for your and your family's dental care needs. You have a choice of two coverage options or you may waive coverage.

Under the Dental Plan, you can choose to enroll in the Preferred Dentist Program (PDP®), administered by MetLife®. Each time you need care, the PDP lets you choose to receive higher benefits by visiting network providers, or to visit any dental provider you want while still receiving some level of benefits for eligible care and services.

Or, you can choose to enroll in the Dental Maintenance Organization (DMO®), insured by Aetna, if the DMO is available in your location. Under the DMO, you receive benefits only when you visit participating network providers. However, unlike the PDP, the DMO has no annual plan maximums that limit your ability to receive benefits for dental care throughout the year.

Preferred Dentist Program (PDP®)

The PDP is a type of dental care arrangement that offers you the freedom to choose how you receive your dental care and services while helping to manage costs.

HOW THE PDP WORKS

Under the PDP, you have a choice each time you need dental care and services:

- **In-Network**, you visit providers who participate in the PDP network of participating dentists, specialists and dental care facilities. This network of participating providers offers care and service at discounted fees. As a result, you generally receive a higher level of benefits at a lower cost to you when you receive dental care and services in-network. In addition, you can visit any network provider each time you need care and services; you do not have to choose a Primary Care Dentist (PCD) like you would under other types of dental options, like the DMO.
- **Out-of-Network**, you visit providers who do not participate in the PDP network. While you can still receive benefits for eligible expenses using non-network licensed providers, you typically pay more out-of-pocket for care and services received out-of-network.

Each time you need to visit a dentist or other care provider you choose between receiving care in-network or out-of-network under the PDP Plan.

IN-NETWORK	OUT-OF-NETWORK
You need to meet a lower deductible before the PDP shares in the cost of most eligible expenses.	You need to meet a higher deductible before the PDP shares in the cost of most eligible expenses.
You pay a lower coinsurance percentage for most eligible expenses than if you received care out-of-network.	You pay a higher coinsurance percentage for most eligible expenses than if you received care in-network.
Your share of the coinsurance amount is applied to pre-negotiated discounted fees, so you generally pay less in out-of-pocket expenses.	Your share of the coinsurance amount is applied to your provider's full fees, up to reasonable and customary limits. You are responsible to pay out-of-pocket any amount above the PDP's reasonable and customary limits for your care, in addition to your share of the coinsurance.
The PDP pays more in annual benefits than if you received care out-of-network.	The PDP pays less in annual benefits than if you received care in-network.
Your PDP dentists typically complete any necessary paperwork for you.	You are responsible for completing and submitting claim forms each time you use a non-network dental provider.

For more details about the Preferred Dentist Program (PDP) option, you can either log on to the MetLife website at **www.metlife.com/mybenefits** or call MetLife Customer Service at **1-800-942-0854**.

Dental Maintenance Organization (DMO®)

The Dental Maintenance Organization (DMO) is a dental care arrangement that offers dental care and services through a network of participating dental providers. If you participate in the DMO, you choose a Primary Care Dentist (PCD) for you and each covered family member from the DMO network. (You can choose a different PCD for each family member.) The PCD manages your dental care and services and is your first point of contact each time you need dental care. Then, if you need specialized dental care, your PCD can refer you to other network providers.

When you receive care through the DMO, which is administered by Aetna, you will show your DMO ID card (which you will receive after enrollment in the DMO) to the network provider to receive benefits. Some of the care and services available are covered at 100%; for others, you will pay a copay each time you visit your PCD and other specialists.

However, if you visit a network dentist other than your PCD to whom you have not been referred by your PCD, or if you visit any non-network dentist, your treatment will not be covered unless it is pre-authorized by Aetna. This means you pay the entire cost for your dental care received out-of-network.

For details about the DMO option, please contact Aetna. They can provide a DMO Summary of Benefits under this option. You can either log on to the Aetna website at **www.aetna.com** or call Aetna Member Services at **1-877-238-6200**.

Keep in Mind

If you participate in the Health Care Spending Account, you can submit any eligible expenses not covered under the Dental Plan to the Health Care Spending Account for reimbursement.

DENTAL PLAN COMPARISON

	PREFERRED DENTIST PROGRAM (PDP®)		DENTAL MAINTENANCE ORGANIZATION (DMO®)
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK
ANNUAL DEDUCTIBLE	Individual: $50 Family: $100	Individual: $150 Family: $300	None
COINSURANCE (PLAN PAYS):			
PREVENTIVE CARE	100%, no deductible	80%, no deductible	Some procedures are covered at 100%, while others require a copay; refer to the DMO Summary of Benefits available from Aetna for a list of benefits under this option and the applicable copays.
BASIC CARE	80%, no deductible	65% after deductible	
MAJOR CARE	60% after deductible	50% after deductible	
ORTHODONTIA (PER CHILD UP TO AGE 19)	50% after deductible	50% after deductible	
ANNUAL MAXIMUM BENEFIT* (PER PERSON)	$2,000, including out-of-network expenses	$1,000, including in-network expenses	None
ORTHODONTIA LIFETIME MAXIMUM (PER CHILD UP TO AGE 19)	$2,000 combined for in-network and out-of-network expenses		None

*Any amounts the PDP pays for eligible expenses in-network or out-of-network cross-apply to both the in-network and out-of-network Annual Maximum Benefits. So, once the PDP pays up to $1,000 for either in-network or out-of-network care, the PDP will not pay anything more toward the cost for out-of-network care for the remainder of the calendar year. For example, if the PDP pays $500 for in-network care and $500 for out-of-network care, you will have met the Annual Maximum Benefit of $1,000 for out-of-network care. In this case, the PDP will share in the cost of eligible expenses for in-network only, paying up to an additional $1,000 in benefits—which meets the in-network $2,000 Annual Maximum Benefit—for the rest of the calendar year.

Vision

The Vision Plan, administered by VSP, can help you pay for your and your family's vision care needs. You can choose coverage or you may waive coverage.

Under the VSP Vision Plan, you can choose—each time you need vision care services—whether to visit network providers or non-network providers, and receive the benefits associated with each. In general, you will receive higher levels of benefits for most vision care and discounts for certain eye care needs when you visit network providers. However, you have the flexibility to choose non-network vision care providers and still receive benefits under the Plan.

To learn more about the VSP Vision Plan, you can log on to their website at **www.vsp.com**.

How the VSP Vision Plan Works

When you and your covered family members need vision care and services, you can choose to receive it:

- **In-Network**, by visiting providers who participate in the VSP network. When you use in-network providers, you pay just $25 to receive an annual eye exam and to purchase lenses and frames, up to certain limits. If you want to purchase contact lenses, the VSP Vision Plan offers a $150 allowance toward the cost of the exam and your contact lenses. In addition, using in-network providers gives you the added advantage of discounts and preferred pricing on additional eye care needs.

Please note: *VSP generally contracts with independent vision care providers and not with chain stores or retail optical providers. Please contact VSP for details on participating vision care providers.*

- **Out-of-Network**, by visiting providers outside the VSP network. When you visit non-network providers, you pay the entire cost for your vision care services out-of-pocket and submit your bill to VSP. Then, VSP provides you with an allowance to cover all or a portion of your cost for eye exams, lenses, frames and contact lenses, less an annual $25 copay per family member.

  When you submit your bill to VSP, they automatically will apply the $25 copay against your allowance for reimbursement for vision care services. In addition, you will not be eligible for VSP's additional discounts or preferred pricing for other eye care needs from providers outside the VSP network.

VSP VISION PLAN COVERAGE		
	IN-NETWORK	OUT-OF-NETWORK
EXAMS One every calendar year per covered person		Plan provides $50 allowance for the cost of an exam
LENSES** One set every calendar year per covered person	$25 copay, includes exam, lenses and frames	Plan provides an allowance for the cost of lenses: ■ Single vision: Up to $32 ■ Bifocals: Up to $50 ■ Trifocals: Up to $68
FRAMES One set every other calendar year per covered person	$150 allowance, plus 20% discount on amount over the allowance	Plan provides $65 allowance for the cost of frames
CONTACT LENSES** One set every calendar year per covered person (in lieu of glasses)	■ Plan provides a $150† annual allowance per covered person for the cost of contact lenses and contact lens exams ■ 15% discount on contact lens exam	Plan provides a $150† annual allowance per covered person for the cost of contact lenses and contact lens exams
LASER VISION CORRECTION: ■ Average 15% off the regular price or 5% off the promotional price from contracted facilities ■ After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor GLASSES AND SUNGLASSES: ■ Average 30% savings on lens options, like progessives and anti-reflective coating ■ 20% off additional glasses and sunglasses (available from any VSP doctor within 12 months of the last covered eye exam)	Discounts and preferred member pricing available; contact VSP directly for details	No discount or preferred pricing

*The Plan provides certain dollar allowance amounts for vision care services, less an annual $25 copay per family member. For example, if you go out-of-network and have an eye exam and purchase single-vision lenses and frames in the calendar year, VSP will reimburse you up to $147 ($50 for exam + $32 for lenses + $65 for frames), minus the $25 copay. In this case, the most you would receive in reimbursement would be $122.

**You may purchase either lenses or contact lenses in any year, but not both in the same year.

†Any portion of your annual allowance amount you do not use toward the purchase of contact lenses or the cost of contact lens exams in any one year will not roll over for use in the following year.

Flexible Spending Accounts

The Flexible Spending Accounts, administered by WageWorks, help you reduce your taxes by letting you contribute a portion of your pay on a pre-tax basis to two different accounts: the Health Care Spending Account and the Dependent Care Spending Account. Then, when you incur certain health-related or certain dependent care expenses during the year, you can request reimbursement from the appropriate account.

FLEXIBLE SPENDING ACCOUNTS	PRE-TAX CONTRIBUTION MINIMUMS AND MAXIMUMS PER CALENDAR YEAR
Health Care Spending Account	■ Minimum $120 ■ Maximum $5,000
Dependent Care Spending Account	■ Minimum $120 ■ Maximum $5,000 ($2,500 if married and filing an individual income tax return)

Be sure to plan your contributions carefully. Federal regulations require you to forfeit any remaining balances at the end of the calendar year. Use it or lose it.

Swipe your Health Care Card for eligible items and services at health care providers and drug stores. You can also use it for eligible over-the-counter items at supermarkets, warehouse and discount stores and any other non health-care merchant that has received an IIAS certification. Go to **www.wageworks.com/iias** for more information on IIAS and how to best use your Card.

How the Flexible Spending Accounts Work: An Overview

In general, here is how the Flexible Spending Accounts work:

- **First**, during enrollment, you elect the amount you want to contribute on a pre-tax basis to the Health Care Spending Account and/or the Dependent Care Spending Account for 2011. (If you contribute to the Health Care Spending Account, a WageWorks Health Care Debit Card will be sent to your home.)
- **Next**, during 2011, a portion of your pay at each pay period will be deducted throughout the year—before federal income and Social Security taxes (and, where applicable, state and local taxes) are withheld.
- **Then**, if you participate in the:
  - — **Health Care Spending Account**, show your WageWorks Health Care Debit Card when you visit your health care providers and use it to pay your out-of-pocket costs, such as copays and deductibles, directly from your Health Care Spending Account. Or you can pay your expenses out-of-pocket and submit a claim.
  - — **Dependent Care Spending Account**, you can either pay your expenses out-of-pocket or submit a claim or you can choose to have WageWorks pay your provider directly.
- You can receive reimbursement under the:
  - — **Health Care Spending Account**, up to your total annual contribution amount at any time during the year.
  - — **Dependent Care Spending Account**, up to the amount in your Dependent Care Spending Account at the time your claim is processed. The remainder of your claim under this Account will be reimbursed to you as additional contributions are made to your Account during the year.

Keep in Mind

If you participate in the Health Care Spending Account, you can submit any eligible expenses not covered under the VSP Vision Plan to the Health Care Spending Account for reimbursement.

The Health Care Spending Account (HCSA)

The HCSA allows reimbursement for eligible health-related expenses you and your eligible family members incur that are not paid by any other health care plan. Even if you do not cover these eligible family members as dependents under the Medical, Dental or Vision Plans, you can still use the HCSA to receive reimbursement for their eligible health-related expenses. However, you must be able to claim those family members as dependents for tax purposes.

Domestic Partners and the Health Care Spending Account
Domestic Partners and their children are not considered qualifying dependents by the IRS. Consequently the Health Care Spending Account cannot be used to pay for expenses incurred on their behalf. However, if you have adopted your partner's child or assumed legal guardianship, you may use the Health Care Spending Account for these expenses.

WHAT IS COVERED	WHAT IS NOT COVERED
Typical eligible expenses include: ■ Deductibles ■ Copays ■ Coinsurance amounts (your share only)	Expenses related to: ■ Cosmetic procedures ■ Health clubs or spas ■ Non-prescribed weight-loss programs
Any out-of-pocket eligible expenses exceeding reasonable and customary limits	Health insurance premiums (or premiums under any other insurance plan)
■ Prescription drugs ■ Hearing care ■ Certain over-the-counter drugs with a prescription	
Other out-of-pocket health care expenses not paid by another medical, dental or vision plan	

Over-the-counter (OTC) medicines will no longer be eligible for reimbursement under the Health Care Spending Account unless they are prescribed by a doctor. For a complete list of eligible expenses under the Health Care Spending Account, please refer to IRS Publication 502, available by visiting the IRS website at **www.irs.gov** or by calling **1-800-TAX-FORM** (1-800-829-3676).

CHANGES TO FLEXIBLE SPENDING ACCOUNTS

You can make changes to your Accounts during the year only if you have a qualified Change in Status. (See "Changing Your Coverage During the Year" on page 29 for more details.)

GRACE PERIOD FOR FLEXIBLE SPENDING ACCOUNT REIMBURSEMENTS

You have until March 31, 2012 to submit claims for expenses you incurred in 2011 and while an active employee.

USE IT OR LOSE IT!

Any money that you contribute but do not use to pay for eligible expenses incurred in 2011 while an active employee under the Health Care Spending Account and Dependent Care Spending Account will be forfeited in accordance with IRS regulations.

You cannot submit any claims for expenses incurred while on an unpaid leave of absence for more than eight weeks. If you return to work, your account may be reinstated and payroll adjustments will be made to maintain your annual election.

The Dependent Care Spending Account (DCSA)

The DCSA allows reimbursement for eligible dependent day care expenses you pay for your dependent's care while you work. If you are married, the Account reimburses you for eligible expenses only if your spouse works, too.

WHAT IS COVERED	WHAT IS NOT COVERED
Typical eligible expenses include:	Expenses not eligible include:
■ Licensed nursery school ■ Qualified child care or adult care centers ■ Day camp ■ Baby-sitters inside or outside your home during working hours ■ Household services for care of an elderly or disabled dependent adult who lives with you	■ Twenty-four hour institutional care, like nursing home services for an elderly parent or grandparent who does not spend at least eight hours a day in your home ■ Care provided by your child who is under age 19, or care provided by anyone else you can claim as a dependent ■ Baby-sitting when you or your spouse are not working ■ Private schools ■ Overnight camp

For a complete list of eligible expenses under the Dependent Care Spending Account, please refer to IRS Publication 503, available by visiting the IRS website at **www.irs.gov** or by calling **1-800-TAX-FORM** (1-800-829-3676).

IMPORTANT INFORMATION ABOUT THE DEPENDENT CARE SPENDING ACCOUNT

Your Eligible Dependents

The dependents for whom you can submit claims for eligible expenses include:

- Your children under age 13
- Your family members of any age (for example, a child, a spouse or a parent) if they are physically or mentally incapable of caring for themselves, provided they depend on you for more than half their support and spend at least eight hours a day in your home

The Dependent Care Federal Tax Credit

The IRS allows you to take a tax credit for your dependent care expenses on an amount up to:

- $3,000 for one dependent
- $6,000 for two dependents

However, you are not allowed to receive reimbursements under the Dependent Care Spending Account and take a tax credit on the same expense. Contact a tax advisor to determine which will provide greater tax savings to you.

Taxpayer Identification Number

Each year, the IRS requires you to report on your annual tax return the taxpayer identification number of each dependent care provider you use. (In some cases, that number could be a Social Security Number.) Before you use the Dependent Care Spending Account, make sure you can report the taxpayer identification number for each of your dependent care providers.

You cannot submit any claims for expenses incurred while you are on a paid or unpaid leave of absence. If you return to work, your account may be reinstated and payroll adjustments will be made to maintain your annual election.

Transportation Management Program

The Transportation Management Program, administered by WageWorks, helps you reduce your taxes by letting you contribute a portion of your pay on a pre-tax basis to a parking account or purchase transit passes directly from WageWorks on a pre-tax basis.

How the Transportation Accounts Work

Buy My Pass
Tell WageWorks which pass you want to buy from which public transportation or van pool agency, and WageWorks will deliver it to your home each month. Depending on your provider, WageWorks can make payments directly to your provider. You make a one-time request that you can change or cancel at any time.

In the unlikely case that the pass you want is not available from the WageWorks online store, then you may be eligible to receive reimbursement for your expenses.

If your pass costs more than the pre-tax maximum allowable benefit, the amount above the pre-tax limit will be deducted directly from your paycheck on an after-tax basis on the last paycheck of the month.

Pay My Parking
Tell WageWorks how much you pay for your parking garage or lot each month and WageWorks will send a payment directly to them each month on your behalf. You need only make a one-time request (that you can cancel in the future).

Pay Me Back
If your parking expenses are unpredictable, pay for them yourself and then get reimbursed. All you need to do is enter the amount you pay for parking each month, then complete a simple claim form and provide proof of service each month. If your parking provider doesn't supply receipts, you can submit an online claim instead.

To access your account on WageWorks:

1. Visit **www.wageworks.com** and click on "Register Now" under "First Time Using This Site?"
2. Enter the required information to authenticate your access
3. On the profile page, create a user name and password and ensure your address information is correct
4. Enter a phone number and email address
5. For reimbursement directly to your bank account, please enter your information in the appropriate boxes
6. Read the User Agreement and confirm your acceptance.

Parking Account
The Parking Account allows you to receive reimbursement for eligible work-related parking expenses. (The Parking Account cannot be used to reimburse expenses incurred by your spouse/domestic partner or other dependents.)

Covered expenses can include the cost for a parking facility at or near your place of work, or at or near a mass transit facility, such as a train or bus station.

WHAT IS COVERED
- Bus
- Train
- Subway
- Ferry
- Parking at or near work

You should budget carefully. Although you don't forfeit any unused funds at the end of the year, you may forfeit any unused balance if you were to leave the Company.

Frequently Asked Questions About the Transportation Management Program

How much will I save?
You can save by using pre-tax dollars to pay for your commuting costs. The exact dollar amount you will save will depend on your individual commute costs.

To estimate your savings, you can use the Commuter Savings Calculator at **www.wageworks.com/commutercalculator**.

What does pre-tax mean?
It means that the costs are deducted from your paycheck *before* federal, state* and local taxes are applied to your pay. This lowers your taxable income, so you pay less in taxes. You do not make any claims on your IRS forms regarding this commuter program or savings. Your savings are all automatic after you enroll.

When is open enrollment?
There's no need to wait until open enrollment as with other benefit plans. You can enroll, change or cancel your commuter benefits any month.

Are there any deadlines?
Yes. Monthly deadlines determine when your request to enroll, change or cancel will take effect. Once you enroll, WageWorks will send you a reminder each month before your deadline.

What if I don't like doing things online?
Call WageWorks at 1-877-924-3967 (1-877-WageWorks) and they will do everything over the phone.

When will I get my commuter pass?
You can expect your pass in the mail before the first day of the benefits month. For example, your November pass will arrive during the last week of October.

What if my pass gets lost in the mail?
If this happens to you, simply call WageWorks and they will assist you right away.

I take public transportation, and I pay to park my car at the transit station. Can I get both my parking and my pass covered?
Yes. Simply enroll for both Public Transportation and Parking.

When will my election be deducted from my paycheck?
Deductions will be made on the first pay period of each month.

*State taxes apply in some states.

Long-Term Care Insurance

The Long-Term Care Insurance Plan, administered by John Hancock Life Insurance Company (USA), is designed to help protect your assets and preserve your freedom of choice and financial independence if you or your eligible family members should require long-term care services.

YOUR COVERAGE OPTIONS ARE AS FOLLOWS:					
DAILY MAXIMUM BENEFIT[1]	OPTION 1	OPTION 2	OPTION 3	OPTION 4	OPTION 5
Nursing Home	$115.00	$175.00	$230.00	$290.00	$345.00
Alternate Care Facility[2]	$86.25	$131.25	$172.50	$217.50	$258.75
Home Health/ Adult Day Care[3]	$69.00	$105.00	$138.00	$174.00	$207.00
Informal Care[4]	$28.75	$43.75	$57.50	$72.50	$86.25
Lifetime Maximum Benefit (5-year)	$209,875	$319,375	$419,750	$529,250	$629,625

[1]The total of benefits payable for all covered services received on any day will not exceed the Nursing Home DMB.

[2]If you are a resident of Kansas, this benefit varies slightly. Call **1-800-777-4204** for more details.

[3]Washington refers to this as adult day health care.

[4]The total benefits payable for all informal care received in a calendar year.

You or your eligible family members who choose coverage under the Plan can receive long-term care services, when needed, in a number of different ways. For example:

- At home from a certified home health or personal care aide
- In the community at an assisted living facility or at an adult day care facility
- In a nursing home or hospice

For more details about the Long-Term Care Insurance Plan, current Plan coverage options and to enroll, please contact John Hancock Life Insurance Company (USA) directly.

Adoption Assistance Plan

The Adoption Assistance Plan reimburses you for certain eligible adoption-related expenses.

Eligible employees can receive an 80% reimbursement for eligible adoption-related expenses subject to a maximum reimbursement per year or per adoption of $5,000. Eligible expenses include:

- Reasonable and necessary adoption fees
- Court costs
- Attorney fees
- Travel expenses

You are eligible for this Plan automatically; you do not need to enroll. Please contact your local Benefits Administrator for more details about the Adoption Assistance Plan.

Short-Term Disability/ Salary Continuation

The Short-Term Disability (STD) Plan provides benefits for all illnesses or disabilities expected to last for more than five days, and is provided to you at no cost. The benefit is 100% or 50% of your pay depending on your length of service. STD continues for up to 26 weeks of disability (six months).

YEARS OF SERVICE	NUMBER OF WEEKS WITH 100% OF PAY	NUMBER OF WEEKS WITH 50% OF PAY
Less than 3 years	2 weeks	24 weeks
3–4 years	4 weeks	22 weeks
5–9 years	6 weeks	20 weeks
10+ years	13 weeks	13 weeks

To receive STD payments, you must report your illness (where applicable) to your supervisor, your HR representative, and to the Plan Administrator, The Hartford Insurance Company. For additional information on STD, please contact your Benefits Administrator.

Long-Term Disability

The Long-Term Disability Plan, administered by Hartford, will provide benefit payments if your illness or disability lasts longer than 26 weeks (180 days).

Basic Long-Term Disability

You automatically receive Basic Long-Term Disability coverage equal to 50% of your pay, up to a monthly maximum benefit of $5,000. The Company pays the entire cost for this coverage.

Employee Optional Long-Term Disability

If you want to elect more long-term disability coverage than what Basic Long-Term Disability provides, you can choose coverage under Employee Optional Long-Term Disability equal to 60% of your pay, up to a monthly maximum benefit of $25,000 (including the Basic Long-Term Disability)

Long-Term Disability Options

BASIC LONG-TERM DISABILITY (provided automatically at no cost to you)	50% of pay, up to a monthly maximum benefit of $5,000
EMPLOYEE OPTIONAL LONG-TERM DISABILITY	60% of pay, up to a monthly maximum benefit of $25,000 (including the Basic Long-Term Disability benefit)

WHAT IS A LONG-TERM DISABILITY?

In general, a qualifying long-term disability is an illness or injury that prevents you from doing your regular job for more than 180 days.

During your first 24 months of receiving benefits under the Long-Term Disability Plan, a long-term disability means you are unable to perform the key duties of your job on a full-time or part-time basis.

After the first 24 months, a long-term disability means you are unable to perform the duties of any job for which you are or may become able to perform based on your education, training or experience.

Important Information about Employee Optional Long-Term Disability

- You may be required to provide Evidence of Insurability (EOI), also known as proof of good health if you are a late entrant in the plan or select Optional Long-Term Disability during a qualified family status change. In the event that satisfactory EOI is not provided, the coverage requiring EOI will revert back to the basic Long-Term Disability.
- **Duration of Benefits**: If you are disabled and begin receiving Long-Term Disability Plan benefits, the payments will continue while you are disabled up to the following limits:

AGE WHEN DISABLED	MAXIMUM DURATION OF BENEFIT PAYMENTS
Prior to age 63	To Normal Retirement Age or 42 months, if greater
63	To Normal Retirement Age or 36 months, if greater
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

Coordination with Other Benefits

Your Long-Term Disability Plan benefits are coordinated with any benefits you receive from other group disability plans (like Social Security or Workers' Compensation). If you are eligible to receive benefits under the Long-Term Disability Plan, the total benefit you receive from all disability plans will equal either 50% or 60% of your pay, based on whether you choose to elect Employee Optional Long-Term Disability coverage.

Any long-term disability benefits you receive from an individual policy you purchase on your own outside the IPG Benefits Program are paid in addition to any benefits you are eligible to receive under the IPG Long-Term Disability Plan. Benefits from an individual policy will be paid according to that policy and will not offset any benefits you receive from the Long-Term Disability Plan.

Life Insurance

Under the Life Insurance Plan, insured by MetLife, your designated beneficiary receives a benefit if you die while covered by the Plan.

The Plan also pays a benefit to you if your spouse/domestic partner or child dies while covered by the Plan.

Basic Life Insurance

You automatically receive Basic Life Insurance coverage equal to 1 x pay, up to a maximum coverage amount of $250,000. The Company pays the entire cost for this coverage.

However, if your Basic Life Insurance coverage is more than $50,000 of coverage and you want to avoid imputed income, you can choose a maximum coverage amount of $50,000. (For more information about imputed income, see "Imputed Income: An Overview" below.)

Employee Optional Life Insurance

If you want to elect more life insurance coverage than what Basic Life Insurance provides, you can choose additional coverage under Employee Optional Life Insurance. You can choose additional coverage from 1 x pay to 8 x pay, up to a maximum coverage amount of $2 million, including your Basic Life Insurance coverage maximum.

Please note: *The cost of coverage under Employee Optional Life Insurance is determined based on age ranges set by MetLife. Since the cost of coverage for 2011 is based on your age at enrollment, your cost could increase during the year if your age increases to the next higher age range during the year.*

In addition, if your pay increases or decreases during the year, your coverage amount will be adjusted accordingly since your coverage amount is a multiple of your pay.

If you and your spouse both work for the company, you cannot be covered as both an employee and dependent and only one person can elect child life insurance.

Spouse Life Insurance

You can choose to cover your spouse or your domestic partner under Spouse Life Insurance. You can choose from $10,000 up to $100,000 in $10,000 increments, or elect to waive coverage.

If you choose coverage under Spouse Life Insurance, the coverage amount you choose cannot exceed your own coverage amount under Basic Life Insurance and Employee Optional Life Insurance combined.

The cost of your spouse or domestic partner coverage is based on their age up to the age of 80. After their 80th birthday, they would not be eligible for Spouse Life Insurance.

Child Life Insurance

You can choose to cover your child(ren) under Child Life Insurance. You have two coverage options or elect to waive coverage:

- 5,000 of coverage per eligible child
- $10,000 of coverage per eligible child

If you choose Child Life Insurance coverage, you automatically cover all of your eligible dependent children at the one cost. (Eligible dependent children under this Plan include children who are more than 14 days old up to age 19, or 26 if a full-time student.)

Evidence of Insurability

You may be required to provide Evidence of Insurability (EOI), also known as proof of good health, based on the elections you make under the Life Insurance Plan for you, your spouse or your domestic partner. When you enroll, you will be notified of any coverage options requiring EOI. In the event that satisfactory EOI is not provided, the coverage requiring EOI will revert back to the lowest threshold that does not require EOI.

IMPUTED INCOME

Under current tax rules any amount of employer paid employee life insurance over $50,000 is considered additional taxable income. You can limit coverage to $50,000. Before you decide, consider the value of additional coverage over $50,000 versus the tax implications on your imputed income.

If you elect to limit your basic coverage to $50,000 you cannot elect additional Employee Optional Life Insurance.

Optional Life Insurance and Dependent Life Insurance may also be subject to imputed income.

For Employee Optional Life Insurance: You will be required to provide EOI if you are:

- A new hire and your election exceeds 3 x pay or $500,000
- Once EOI is approved, you will not need to submit EOI again in the future for a one-time increase in coverage during open enrollment.
- A participant in the 2010 Benefits Program and for 2011, you:
  - — Increase your coverage by 2 x pay or more
  - — Increase your coverage so that it crosses the threshold of 3 x pay or $500,000

For Spouse Life Insurance: Your spouse or domestic partner must provide EOI if they have been hospitalized within the last 90 days before the request for coverage and if you are:

- A new hire and the election exceeds $50,000
- Once EOI is approved, your spouse will not need to submit EOI again in the future for a one-time increase in coverage during open enrollment.
- A participant in the 2010 Benefits Program and for 2011, you
  - — Increase coverage by more than $10,000 during annual enrollment
  - — Increase coverage so it crosses the threshold of $50,000
  - — Currently have no spouse coverage

About Beneficiaries

Under Basic Life Insurance and Employee Optional Life Insurance: You need to choose a beneficiary by logging on to **www.interpublicbenefitsonline.ehr.com** and completing the necessary information. You can choose more than one beneficiary. However, you must decide the percentage of any benefit payable to each beneficiary. The total percentage of your benefit for all beneficiaries must equal 100%. Also, you can change your beneficiary at any time.

Under Spouse Life Insurance and Child Life Insurance: You automatically are the beneficiary if your spouse/domestic partner or child dies while covered under these Plans.

See pages 23 and 30 for additional information regarding beneficiaries.

	LIFE INSURANCE OPTIONS	
BASIC LIFE INSURANCE (PROVIDED AUTOMATICALLY AT NO COST TO YOU)	1 x pay, up to $50,000 coverage maximum	1 x pay, up to $250,000 coverage maximum
EMPLOYEE OPTIONAL LIFE INSURANCE	You choose among the following eight options, up to a combined coverage maximum of $2 million between Basic Life Insurance and Employee Optional Life Insurance: ■ 1 x pay ■ 4 x pay ■ 7 x pay ■ 2 x pay ■ 5 x pay ■ 8 x pay ■ 3 x pay ■ 6 x pay	
SPOUSE LIFE INSURANCE*	You can choose from $10,000 up to $100,000 in $10,000 increments.	
CHILD LIFE INSURANCE (PER CHILD COVERAGE AMOUNT)	■ $5,000 ■ $10,000	

*Spouse Life Insurance provides coverage for a spouse or domestic partner and cannot exceed your coverage amount.

Accidental Death and Dismemberment Insurance

Accidental Death and Dismemberment Insurance can provide benefits if you or a covered family member suffers a specific accidental injury or dies as a result of an accident. You can choose from nine coverage amounts and between two coverage categories: Employee only (for you) and Family (for you and your eligible dependents).

	ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE COVERAGE
COVERAGE AMOUNTS	You choose among the following nine coverage amounts: ■ $50,000 ■ $150,000 ■ $500,000* ■ $75,000 ■ $200,000 ■ $750,000* ■ $100,000 ■ $250,000* ■ $1,000,000*
COVERAGE CATEGORIES	You can choose: ■ Employee only, to cover yourself under the Plan ■ Family, to cover you and your eligible family members under the Plan If you choose Family coverage, you need to be aware of the following coverage amounts for your eligible family members. For your spouse/domestic partner: ■ 60% of the coverage amount you choose, if you have no children eligible for coverage under the Plan ■ 50% of the coverage amount you choose, if you have children eligible for coverage under the Plan For your eligible children: ■ 20% of the coverage amount you choose, if you are not married or do not have a domestic partner eligible for coverage under the Plan ■ 15% of the coverage amount you choose, if you are married or have a domestic partner eligible for coverage under the Plan

*Limited to coverage of up to 10 x Basic Annual Salary

How the Accidental Death and Dismemberment Insurance Plan Works

If you choose coverage under the Accidental Death and Dismemberment Insurance Plan and you or a family member suffers an injury or dies as a result of an accident, the Plan will pay the following benefits:

ACCIDENTAL INJURIES COVERED UNDER ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

	THE PLAN PAYS BENEFITS IN THESE AMOUNTS FOR:		
IF YOU OR YOUR COVERED FAMILY MEMBER SUFFERS A LOSS OF:	You	Your spouse or domestic partner	Your children
LIFE	100% of your coverage amount		
TWO OR MORE OF THE FOLLOWING: HAND, FOOT, SIGHT IN ONE EYE, OR SPEECH AND HEARING	100% of your coverage amount	50% or 60% of your coverage amount*	15% or 20% of your coverage amount*
ONE HAND, ONE FOOT, SIGHT IN ONE EYE, SPEECH OR HEARING	50% of your coverage amount		
THUMB AND INDEX FINGER OF THE SAME HAND	25% of your coverage amount		

* See page 22 for details on percentages.

About Beneficiaries

If you:

- Die as a result of an accident, your beneficiary will receive your Accidental Death and Dismemberment Insurance Plan benefits (in addition to any benefits under the Life Insurance Plan).
- Suffer an accidental injury or dismemberment, you will receive any Plan benefits.

If your covered family member:

- Dies as a result of an accident, you will receive a benefit from the Accidental Death and Dismemberment Insurance Plan (in addition to any benefits under the Life Insurance Plan).
- Suffers an accidental injury or dismemberment, your family member will receive any Plan benefits.

Please note: *If you do not designate a beneficiary, the beneficiaries you designate under the Life Insurance Plan will be your beneficiaries under the Accidental Death and Dismemberment Insurance Plan.*

See page 30 for additional information regarding beneficiaries.

Identity Theft Assistance

This voluntary benefit helps you and your family protect your credit and personal information. It offers a credit monitoring service that will alert you to suspicious account activity. It also assists you in restoring your credit by notifying creditors and other agencies should you become the victim of identity theft. In addition, it will reimburse you for covered out-of-pocket expenses you may incur while restoring your credit.

Identity Theft Assistance helps you every step of the way—by processing paperwork and making necessary phone calls to government agencies and credit bureaus. While many recovery programs will tell you what to do, the representatives at our 24/7 Emergency Call Center actually do the work for you.

ID Theft Assist Representatives will:

- **Notify agencies and creditors**
  - — Access one-time, full and complete reports and scores from all three credit reporting agencies
  - — Notify and place fraud alerts with all three agencies
  - — Contact creditors with itemized fraudulent account statements for each occurrence
  - — Fill out and submit an ID Theft Affidavit on your behalf to authorities, credit bureaus and creditors
- **File reports**
  - — Capture all necessary information to act immediately on your behalf
  - — Report your ID theft to the Federal Trade Commissions
  - — File a criminal report and forward it to creditors and the Social Security Administration
  - — Draft an impact letter should your thief be arrested and go to trial
- **Help restore your identity**
  - — Cancel and replace checks, ATM and credit cards
  - — Extend emergency cash advances
  - — Provide translation services
  - — Review legal documents
  - — Arrange access to professionals to help you deal with the emotional trauma of identity theft
  - — Offer legal consultations, intervention and advocacy
  - — Free, three-in-one continuous credit monitoring
  - — Post-incident identity tracking with alerts when changes are made to your credit score

Business Travel Accident

You may be covered for any accidents or losses incurred when traveling for business.

Eligibility

- Class 1—All worldwide employees who are regularly scheduled to work 20 hours or more per week.
- Class 2—All worldwide Directors not included in Class 1.
- Class 3—All Spouses of Classes 1 and 2 employees accompanying them on authorized business or while involved in relocation.
- Class 4—All Dependent Children of Classes 1 and 2 employees accompanying them on authorized business or while involved in relocation.

Benefit Amount

- Class 1—10 times base annual earnings* with a minimum of $100,000 up to a maximum of $1,000,000
- Class 2—$1,000,000
- Class 3—$50,000
- Class 4—$25,000

*Base annual earnings is defined as the employee's base annual earnings at the time of the covered accident, excluding overtime, profit-sharing, bonuses or other supplemental compensation.

ACCIDENTAL DEATH AND SPECIFIC LOSS BENEFITS

Life	Principal Sum
Both Hands or Both Feet or Both Eyes	Principal Sum
One Hand and One Foot	Principal Sum
One Hand and One Eye or One Foot and One Eye	Principal Sum
One Hand or One Foot or One Eye	One-Half of Principal Sum
Speech and Hearing	Principal Sum
Speech or Hearing	One-Half of Principal Sum
Thumb and Index Finger of the Same Hand	One-Fourth of Principal Sum

Travel Assist

To receive these services, you must be outside of a 100-mile radius from your home, regular place of employment or assignment.

- **General Assistance**—Help with access to translations, consulates, government agencies, and other service providers that can help with travel-related problems.
- **Emergency Message Center**—In case of an emergency, you can leave or receive emergency messages.
- **Pre-Departure Services**—Provides information on immunization requirements, appropriate medical exams and treatments, passport and visa requirements, weather, and travel hazards.
- **Lost Baggage/Passport**—Provides telephone advice to a traveler whose baggage is lost or delayed by a carrier. Also notifies the appropriate authorities of a traveler's lost passport and provides directions for replacement.
- **Evacuation and Repatriation**—AIG can coordinate emergency medical evacuation or if life is lost while traveling, AIG can coordinate the repatriation of the remains.
- **Travel Medical Emergency Services**—Help you obtain local medical care, monitor the quality and cost of the hospital treatment, confirm travel, verify medical expense insurance, guarantee payment to the provider of medical services using your financial resources and arrange the payment of non-insured medical expenses.
- **Legal Assistance**—Help arrange local attorneys, embassies, and consulates. Help coordinate bail, cash advances, or guarantee of payment for legal service, which can be arranged through your financial resources. AIG can also keep a communication link between you, your family and your employer.
- **Emergency Cash**—In coordination with your finances, AIG can provide cash through banks, consulates, hotels and Western Union.
- **Travel Agency Services**—Can help replace lost or stolen airline tickets through your credit card. Pre-paid tickets can be delivered by mail courier or collected at an airline counter.

Group Legal

The Group Legal Plan, administered by Hyatt Legal Plans, Inc., a MetLife company, provides you and your family with access to a nationwide network of attorneys who can provide advice and assistance on a broad range of personal legal matters. You can choose coverage or elect to waive coverage.

Under the Group Legal Plan, you can choose—each time you need legal assistance—whether to visit network attorneys or non-network attorneys, and receive the benefits associated with each. In general, most network-provided legal assistance eligible under the Plan is covered at 100%; however, you have the flexibility to use any licensed attorney and still receive some benefits under the Plan.

How the Group Legal Plan Works

If you choose coverage under the Group Legal Plan, you have the freedom to choose legal services through the Plan's network of attorneys, or you can choose to visit any out-of-network licensed attorney and still receive benefits for eligible expenses. If you use attorneys:

- **In-Network,** most eligible legal services are covered by the Group Legal Plan at 100%, while others are available at a discount. Most in-network eligible legal services allow for unlimited office and phone consultations. There are no copays, waiting periods, hour limits or claim forms required for eligible services.
- **Out-of-Network,** services are reimbursed according to a set schedule of fees. Please contact Hyatt Legal Plans for additional information on maximum reimbursement amounts.

Finding Network Attorneys
To find attorneys who participate in the Group Legal Plan, contact Hyatt Legal Plans through their web site at ***www.legalplans.com*** *using the password 4560010, or call them directly at* ***1-800-821-6400*** *to locate network attorneys in your area.*

Please note: *The Group Legal Plan does not cover any employment-related issues.*

WHAT IS COVERED UNDER THE GROUP LEGAL PLAN

CONSUMER PROTECTION
- Consumer protection matters
- Small claims assistance

DEBT MATTERS
- Debt collection
- Personal bankruptcy

DEFENSE OF CIVIL LAWSUITS
- Administrative hearings
- Civil litigation defense
- Incompetency defense

DOCUMENT REVIEW
- Any personal legal document

REDUCED FEES
- For personal injury, probate and estate administration matters

DOCUMENT PREPARATION
- Affidavits
- Deeds
- Demand letters
- Notes and mortgages

FAMILY LAW
- Name change
- Premarital agreement
- Uncontested adoption
- Uncontested guardianship

JUVENILE MATTERS
- Juvenile defense

REAL ESTATE MATTERS
- Eviction defense
- Tenant negotiations
- Refinancing of home
- Sale or purchase of home

TRAFFIC MATTERS
- Traffic defense (excluding driving under the influence)
- Restoration of driving privileges

WILLS AND ESTATE PLANNING
- Living wills
- Powers of attorney
- Wills and codicils
- Trusts

Coverage also includes unlimited in-network telephone advice and office consultations on virtually any legal matter.

Group Home and Auto Insurance Program

The Group Home and Auto Insurance Program offers you the opportunity to obtain quotes at group rates from two top-rated insurance providers, MetLife and Liberty Mutual.

Each provider offers:

- Special group rates and/or discounts
- Additional discounts, such as multi-car, safety devices, multi-policy and a responsible driver discount
- Convenient payment options, including payroll deduction, bank account deduction, or credit card billing (in most instances, with no down payments or installment fees)
- New car replacement coverage, mechanical parts replacement, full replacement cost coverage for special parts and more
- 24-hour claim reporting
- Year-round application/enrollment

Note: Not all discounts apply in all states or for each carrier. Please check with MetLife and/or Liberty Mutual for their specific discounts.

Benefits Basics

Who Is Eligible

You are eligible for coverage under the Benefits Program if you are an employee of IPG or one of the operating units that has adopted the Benefits Program and you are regularly scheduled to work 20 hours or more per week.

Please note: *Part-time employees hired for temporary projects or interns are not eligible for coverage under the Benefits Program.*

Under the Benefits Program, you can also choose coverage for:*

- Your spouse
- Your domestic partner (includes a couple with a valid marriage license that is recognized by their state of residence)
- Your unmarried dependent children, stepchildren and children of your domestic partner up to age 19, or 26 if enrolled as a full-time student, or up to any age for those who are mentally or physically incapable of self-support
  - — For medical, dental and vision coverage, your children and stepchildren or your domestic partner's children, up to age 26 regardless of dependent, student or marital status

*You may be requested to provide documentation to support a covered person's status, such as a birth certificate or a marriage certificate.

When Coverage Begins

Coverage under the Benefits Program begins:

- January 1, 2011, if you are enrolling during the annual enrollment period
- Retroactive to the date of a Change in Status, if benefits changes are made within 31 days of the date of the status change (see "Changing Your Coverage During the Year" on page 29 for more details on Changes in Status)
- Retroactive to the date you first become eligible if you enroll within 31 days of your eligibility date
- One month from your date of hire if you are enrolling as a new hire
- One month from your rehired date if rehired after six months
- No waiting period if you're rehired within 31 days (defaulted to prior elected benefits)
- No waiting period if you're rehired after 31 days and less than six months (no waiting period; however, must re-elect all benefits)

If you are not actively at work on January 1, 2011, some plan coverages may be impacted until you return. This does not apply to employees who are out on paid time off. Check specific plan details or contact your local Benefits Administrator if you want more information or have questions.

Cost of Coverage

The Company provides you with coverage automatically at no cost to you for the following:

- Employee Assistance Program (EAP)
- Basic Long-Term Disability
- Basic Life Insurance
- Business Travel Accident Insurance

For the following Plans, you pay your share of the cost of coverage on either a pre-tax basis or an after-tax basis. The amount you pay will be deducted automatically from your paycheck (except where indicated) throughout the year. The amount deducted from each paycheck generally is for the prior coverage period (i.e., from your last paycheck to the current pay date).

Your cost for the following Plans will be deducted on a pre-tax basis, which saves you money by lowering your taxable income:

- Medical
- Dental
- Vision
- Flexible Spending Accounts
- Transportation Accounts

Your cost for the following Plans will be deducted on an after-tax basis:

- Optional Long-Term Disability
- Optional Life Insurance
- Spouse and Child Life Insurance
- Optional Accidental Death and Dismemberment Insurance
- Identity Theft Assistance
- Group Legal
- Group Home and Auto Insurance (you can elect payroll deductions or you can make payments directly to the insurance company)
- Long-Term Care Insurance (you make payments directly to the insurance company)

IMPORTANT INFORMATION ABOUT DOMESTIC PARTNER COVERAGE

A domestic partner is a person of the same or opposite sex who has a single, dedicated relationship with you. To be eligible for domestic partner coverage, you and your domestic partner must meet certain requirements. In addition, the Benefits Program covers children of your domestic partner, whether or not you have legally adopted them.

Keep in mind, under current tax laws, the cost of coverage for domestic partners and children of domestic partners cannot be paid on a pre-tax basis under Medical, Dental and Vision. If you are choosing coverage for your domestic partner or his or her children under these Plans, the portion of your cost of coverage for their coverage will be deducted from your paycheck on an after-tax basis. The Company's portion of the cost of their coverage will be considered imputed income to you, and the value of that imputed income will be taxed.

The Health Care Spending Account cannot be used to pay for expenses incurred on behalf of domestic partners and their children. However, if you have adopted your partner's child, you may use the Health Care Spending Account for these expenses.

Please contact your local Benefits Administrator for more details about domestic partner coverage.

Changing Your Coverage During the Year

If you have a Change in Status during the year, you may be eligible to make certain changes to your Benefits Program coverages. Changes in Status may include:

- Marital status (for example, marriage, death of your spouse, divorce, legal separation, and annulment)
- The number of your dependents (for example, the birth, adoption or placement for adoption of a child, or the death of a family member)
- Employment status for you or your spouse (for example, commencement or termination of employment, a strike or lockout, commencement of or return from an unpaid leave of absence, change in worksite or other changes in employment that cause you or your spouse to gain or lose eligibility under the Benefits Program or another company's benefits program)
- Life events that cause your dependents to satisfy or cease to satisfy eligibility requirements under the Benefits Program (like attainment of a certain age or a change in student status)
- Residence for you, your spouse and/or your dependent children (if your current plan is not offered in your new area)

If you are eligible to make a benefit change mid-year due to a Change in Status, you must make the benefit change within 31 days of the date of the qualifying event. In addition, the benefit changes you make must be consistent with your status change. For example, if you get married, you can add your spouse to your coverage. If you get divorced, you can drop your ex-spouse from coverage. However, in both cases, you cannot change plans.

For more details about Changes in Status and the types of changes you may be eligible to make, please contact your local Benefits Administrator. (Please note: Since you can enroll or make changes to the Transit and Parking Accounts on a monthly basis, Changes in Status do not apply to these accounts.)

INTERPUBLIC BENEFITS ONLINE

In addition to accessing the web site to enroll for benefit coverage, you will have access to your benefits information 24 hours a day 7 days a week. You can update dependent information, make life insurance beneficiary designations and make certain elections related to qualified work or family status changes right from your home or office. The site also provides access to the **Plan Cost Estimator**. Just go to **www.interpublicbenefitsonline.ehr.com**.

When Coverage Ends

Your coverage under the Benefits Program or under any one of the benefit plans will end if:

- The Benefits Program or one of the benefit plans is terminated
- You are no longer eligible for coverage under the Benefits Program
- You fail to make required contributions
- Your employment with the Company terminates
- You retire
- You die. Medical coverage only will continue for enrolled dependents until the last day of the month following the month in which you died.

Coverage for your dependents will end if:

- Your coverage under the Benefits Program or under one of the benefit plans ends
- Your dependent child no longer qualifies as a dependent. Benefits continue until the end of the month of their birthday or graduation

Continuation of Benefits

An eligible employee who leaves the Company or who loses coverage for reasons other than termination of employment, may be eligible to continue medical, dental, vision and EAP benefits pursuant to the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA). In most circumstances, an individual may continue the above benefits for up to 18 months by paying the full cost of coverage plus a 2% administrative fee. You will receive notification of your COBRA rights following your coverage end date.

Genetic Information Nondiscrimination Act (GINA)

This act prohibits health coverage discrimination and employment discrimination based on genetic information about plan participants and the family members of plan participants.

Terms to Know

- **Annual Maximum Benefit:** The most the PDP Dental Plan will pay toward your costs for preventive care, basic services and major services each year.
- **Basic Annual Salary:** Under Optional Accidental Death and Dismemberment, your annual salary or base compensation, not including overtime or any bonuses.
- **Beneficiary:** The person, institution, estate or trust you choose to receive benefits if you die while covered under the Life Insurance and Optional Accidental Death and Dismemberment Insurance Plans. You automatically are the beneficiary for your dependents if they die while covered under Spouse or Child Life Insurance and the Optional Accidental Death and Dismemberment Insurance Plan. If no beneficiary designation is on file any benefits payable will be paid to your estate or in accordance with the terms of the applicable Plan.
- **Coinsurance:** The percentages of eligible health care expenses you and a health care plan pay after you meet your deductible and any applicable copays.
- **Copay:** A payment you make for certain types of care and services each time you receive them under the Medical, Dental and Prescription Drug Plans.
- **Dental Care:**
  - — Preventive Care: Includes exams, cleanings, fluoride treatments, X-rays and sealants up to certain age limits and frequencies
  - — Basic Care: Includes fillings, extractions, endodontics, space maintainers, oral surgery, periodontics, and general anesthesia
  - — Major Care: Includes bridgework, inlays, onlays, crowns, and dentures
  - — Orthodontia: Includes diagnostic procedures, orthodontic services and supplies, surgical, appliances and functional therapy. Orthodontia coverage is limited to children up to age 19.
- **Deductible:** The amount you pay each year for eligible expenses before a health care plan begins covering your eligible care and services. Copays, amounts above reasonable and customary limits, the Non-Notification Penalty and certain coinsurance amounts for mental health and substance abuse care do not apply.
- **Imputed Income:** The value of the amount of Company-provided life insurance coverage above $50,000, and the Company's portion of the cost for domestic partner-related coverage under Medical and Dental.
- **Non-Notification Penalty:** The $250 amount you pay out-of-pocket under the PPO choices for receiving certain types of health care services, like surgery or inpatient stays in a hospital, without notifying UnitedHealthcare at least five days in advance (or within 48 hours after services are provided for emergency-related care). The Non-Notification Penalty is in addition to any other amount you need to pay and does not apply against your deductibles or out-of-pocket maximums.
- **Orthodontia Lifetime Maximum:** The most the PDP Dental Plan will pay toward your total costs for orthodontia for each dependent eligible to receive orthodontia care and services.
- **Out-of-Pocket Maximum:** The total amount you pay "out-of-pocket" for certain eligible expenses in a calendar year before the Medical Plan pays 100% of your eligible medical expenses. Copays, amounts above reasonable and customary limits and the Non-Notification Penalty do not apply.
- **Pay:** Different plans have different definitions of pay. Under the:
  - — Life Insurance Plan, pay is defined as your base pay, including any voluntary deferred compensation.
  - — Long-Term Disability Plan, pay is defined as your base pay plus your most recent annual performance-based bonus (if applicable) for the prior year.
- **Reasonable and Customary Limits:** The normal range of fees for care and services charged by health care providers in a given geographic area, as determined by the claims administrator.

IF YOU HAVE QUESTIONS ABOUT	YOU CAN CONTACT
MEDICAL	*UnitedHealthcare Customer Service for the UnitedHealthcare Choice Plus Network PPO1 and PPO2, and for United Behavioral Health (UBH):* ■ By phone: **1-866-679-0946**, Monday through Friday from 8:00 a.m. to 8:00 p.m. (Eastern Standard Time) ■ On the Internet: – For the PPO choices: **www.myuhc.com** – For UBH: **www.liveandworkwell.com** (access code 702551)
AETNA NATIONAL EPO	■ By phone:**1-866-253-8886** for the Aetna Open Access Select EPO ■ On the Internet: **www.aetna.com**
PRESCRIPTION DRUG	Express Scripts (ESI) ■ By phone: **1-888-418-2589** ■ On the Internet: **www.express-scripts.com**
EMPLOYEE ASSISTANCE PROGRAM (EAP)	Corporate Family Network (CFN): ■ By phone: **1-888-777-0052** (1-877-267-1428 for the hearing impaired), 24 hours a day, seven days a week ■ On the Internet: **www.moretolifeonline.com** – User name: IPG – Password: guest
DENTAL	MetLife® Customer Service for the Preferred Dentist Program (PDP®): ■ By phone: **1-800-942-0854**, Monday through Thursday from 8:00 a.m. to 11:00 p.m. and Friday from 8:00 a.m. to 8:00 p.m. (Eastern Standard Time) ■ On the Internet: **www.metlife.com/mybenefits** – Company name: Interpublic ■ Group Plan 36082 *Aetna Member Services for the Dental Maintenance Organization (DMO®):* ■ By phone: **1-877-238-6200**, Monday through Friday from 8:00 a.m. to 6:30 p.m. (Eastern Standard Time) ■ On the Internet: **www.aetna.com** ■ Group Plan 800128
VISION	*VSP Customer Service:* ■ By phone: **1-800-877-7195** – Monday through Friday from 9:00 a.m. to 10:00 p.m. (Eastern Standard Time) ■ On the Internet: **www.vsp.com** ■ Group Plan 12197388
GROUP LEGAL	*Hyatt Legal Plans* ■ By phone: **1-800-821-6400** – Monday through Thursday from 8:00 a.m. to 7:00 p.m. and Friday from 8:00 a.m. to 6:00 p.m. (Eastern Standard Time) ■ On the Internet: **www.legalplans.com**
IDENTITY THEFT ASSISTANCE	*ID Theft Assistance:* ■ By phone: **1-877-439-7309** ■ On the Internet: **www.aia-online.com/ipg**
FLEXIBLE SPENDING AND TRANSPORTATION ACCOUNTS: ■ Health Care Spending Account ■ Dependent Care Spending Account ■ Transit Account ■ Parking Account	*WageWorks Customer Service:* ■ By phone: **1-877-924-3967**, Monday through Friday from 5:00 a.m. to 5:00 p.m. (Pacific Standard Time) ■ On the Internet: **www.wageworks.com**
LONG-TERM CARE INSURANCE	*John Hancock Life Insurance Company (USA):* ■ By phone: **1-800-777-4204** (1-800-255-1808 for the hearing impaired) – Monday through Friday from 8:30 a.m. to 6:30 p.m. (Eastern Standard Time) ■ On the Internet: **http://ipg.jhancock.com** – Username: ipg – Password: mybenefit
TRAVEL ASSISTANCE SERVICES	■ By phone: **1-800-626-2427** – Provide the Company name, Assistance Number (**1-999-806-8135**) and Policy Number (**1-PAI-806-8135**)
GROUP HOME AND AUTO	*Liberty Mutual* ■ By Phone: **1-888-933-3788** ■ On the Internet: **www.libertymutual.com/interpublicgroup** *Metlife Auto and Home* ■ By Phone: **1-800-438-6388** ■ On the Internet: **www.metlife.com/mybenefits**

This Benefits Guide provides a general description of the various benefit plans offered by The Interpublic Group of Companies, Inc. (“the Company”) to its employees and employees of participating units in 2011. This Benefits Guide is provided to assist you in making elections during enrollment for the 2011 plan year. The information in this Benefits Guide is subject to and qualified by the terms and conditions contained in the official plan documents, including summary plan descriptions, for the plans that provide the benefits listed in this Benefits Guide. This Benefits Guide is not an official plan document or summary plan description for the benefit plans. Although the Company intends to continue the benefit plans indefinitely, the Company reserves the right to change, amend or terminate any of the benefit plans at any time. For more information about the benefit plans, please contact your local Benefits Administrator.